THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

Representative Michael C. Burgess
1721 Longworth House Office Building
Washington, DC 20515

Dear Representative Burgess:

On behalf of the Catholic Health Association, I am writing in support of your amendment that would temporarily waive federal rules on governance and ownership under the Federally Qualified Health Center (FQHC) Look Alike program. Your amendment is an important recognition of the work of the private health care safety net, and would allow many of our members to further expand access to primary and preventive services to low income families in their communities.

In response to a study by the Institute of Medicine, which acknowledged that the majority of safety net care is provided by private, not for profit facilities but was limited to studying the role of publicly funded entities, the Catholic Health Association asked the Georgetown University's Institute for Health Care Research and Policy to examine the role of the private health care safety net. The Georgetown study concluded that private, not for profit facilities play core or primary roles in the local safety net. The study confirmed that the uninsured benefit from the role the private safety net and that the private sector face pressures similar to the ones impacting their publicly funded peers.

In my previous position as President and CEO of Providence Hospital, I was asked by the community residents living in the Sursum Corda neighborhood, one of the poorest communities in Washington, DC, to come to their community and open a health center. In 1996, I did just that. The Perry Family Health Center is housed in a historic former school that is less than one mile from the nation's Capitol. Thirty percent of the residents in the immediate area served by the Center are below the poverty level; over 54 percent are below 200 percent of poverty. At last count, the Center had an annual patient census of about 15,000, with an additional 3,000 community service assistance encounters.

The goal of the Center is to provide the people it serves with a "medical home," where a patient is seen regardless of ability to pay and where a patient may routinely seek medical care. Building on that concept, the Center also provides timely access to specialty providers and hospital services. Clinical outcomes are significantly enhanced as a result of the Center's access to Providence Hospital's real-time patient information system, enabling it to track patients through the continuum of care. A major advantage of the Center's connection with Providence Hospital is that the Center's patients gain immediate access to specialty providers. Such timely access helps to produce better health care outcomes. Similarly, the hospital-center connection facilitates timely provider follow-up to emergency room care, which helps to reduce "ER frequent flyers."

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The Perry Family Health Center relies on public and private insurance for funding, as well as grants and local foundations. Providence Hospital also provides a subsidy. Keeping the Center financially afloat, however, is an ongoing challenge. Only about 6 percent of the people served by the Center have private insurance. About 14 percent are uninsured or pay on a sliding fee scale (amounts that fall far short of actual costs). The remaining 73 percent are covered through the DC Health Care Alliance (DC Alliance). Neither Medicaid nor DC Alliance pays enough to cover the Center's costs of caring for those program's beneficiaries. As a result, the Center is experiencing a serious revenue shortfall, jeopardizing its future and preventing it from expanding to meet the increasing needs of its community.

The Perry Family Health Center has found that its model of integrated services produces important and measurable improvements in patients' health and well-being. For example, a reduction in avoidable hospitalizations for adults and children has been measured for the Center's area. There also has been a significant reduction in avoidable hospitalizations for

elderly residents, as well as reduced use of hospital emergency departments for residents of all ages in the community.

On measurable indicators of quality, the Center compares favorably with other health centers. Since its initial opening, the Center has been successful in achieving accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). On HEDIS (Health Plan Employer Data Information Set), the Center has scored well (and above Medicaid managed care plan threshold requirements) for emergency room utilization, immunization rates, prenatal care, newborn and infant care, and women's health measures. Finally, patients have indicated high satisfaction with the Center's services. Such satisfaction scores tend to correlate with high quality care.

The two exceptions to current FQHC requirements proposed by your amendment would not weaken the governance nor reduce the responsiveness of private health centers to patient concerns. A governance exemption is already available under the law for Native American tribes, public agencies, sparsely populated areas, and for programs serving special populations such as migrant and seasonal workers. Nor would these exemptions gut the essential nature of the Community Health Centers program because this proposal does not change current law as is applies to them. Instead, your amendment would expand access to high quality health care services to those who would otherwise go without.

We appreciate your leadership on this issue, and are pleased to offer our support.

Sincerely,

Sr. Carol Keehan, DC
President and CEO
The Catholic Health Association